DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue, NW
Washington, DC 20307-5001

HR-1 Nursing Policy 24 June 2005

Nursing Staff Plan

1. PURPOSE.

To provide guidelines for the assignment and distribution of nursing personnel.

2. REFERENCES.

a. FM 8-501, The Workload Management System for Nursing, Nov 1990.

b. Uniform Chart of Accounts Personnel Utilization System (UCAPERS) User's Guide for Patient Acuity Data Entry, 1 Oct 1993.

c. Comprehensive Accreditation Manual for Hospitals (CAMH), Joint Commission on Accreditation of Healthcare Organizations, 2005.

d. ANA Policy Statement, "Principles for Nurse Staffing", 1999.

3. POLICY.

Staffing decisions are based on historical and current workload data, projected personnel gains and losses, and professional nursing judgment. Inpatient nursing units are staffed based on workload data obtained from a variety of sources to include the Workload Management System for Nurses (WMSN) and the Automated Staffing Assessment Model. The Automated Staffing Assessment Model and locally determined benchmark, and/or Tables of Distribution and Allowances (TDA) will be used for staffing outpatient clinics and nursing units that do not generate WMSN data.

4. STAFFING PROCESS.

a. Department Level (Permanent Staff).

1) The distribution of staff is determined by the Chief, Nursing Administration, Clinical Nursing Section Chiefs, Chief Clinical NCO and Clinical Nursing Section NCOICs.

This publication supersedes NPOL HR-1 dated 22 April 2002.

2) Staffing requirements are evaluated and revised periodically, utilizing the most current 12-month workload data in concert with unique mission requirements. The Head Nurse and NCOIC formulate a unit nursing core staff plan. Augmentation is accomplished by: detailing individuals from one area to another, supplementing core staff with intermittent/contract employees, adjusting staffing schedules by initiating the "on call" roster, or soliciting volunteers from the permanent staff to work overtime.

3) Patient care variables include:

a) Patient acuity

b) Unit census

c) Age and functional ability

d) Communication skills and abilities

e) Cultural and linguistic diversities

f) Severity and urgency of current condition

g) Scheduled procedure(s)

h) Ability to meet care requirements

i) Patient social support

j) Specific identified by the patient and by the nurse.

4) Unit variables include characteristics of the unit's care intensity and configuration and delivery of support functions. Intensity of care includes level and variability of care, admissions, transfers, discharges, and work load.

5) Staff related variables include:

a) Experience with patient population

b) Experience level

c) Education and preparation

d) Language capabilities

e) Length of assignment on unit

f) Nursing specialty

g) The number and competencies of staff with whom the professional nurse must collaborate and supervise.

6) Organization related variables include:

a) Support services (occupational therapy, physical therapy, clerical, transport, housekeeping, laboratory)

b) Access to timely, relevant and accurate information (automated record, Integrated Clinical Database, internet and organization intranet)

c) Time available to supervise and collaborate with staff

d) Opportunity for care coordination and patient/family education

e) Time for coordination with non-licensed nursing staff

b. Staffing Documentation

1) Unit schedules reflect the projected staffing for each day of each week in the month and are maintained at the unit level. Visual Staff Scheduler PRO is the software program used to develop and record the schedule for staff.

2) Staffing reports ("People Sheets") for each unit reflect the names of the nursing staff assigned to work on each shift, their license level, the patient census at the end of each shift, the number of beds by gender type available at the end of each shift, the nursing care hours based on WMSN, and the number of patients in restraints.

a) The nursing care hours (NCH) determined on the night shift or at the beginning of the day shift will be used to project the staffing needed for the next twenty-four hours, by shift.

b) The ratio of actual staff versus required staff from the WMSN data will be reported as a percentage of RNs, LPNs and technicians available on each shift. The staffing reports will reflect the supervisor's assessment of staffing adequacy and actions taken.

c) The charge nurse will prepare the projected staffing reports and give it to the Section Supervisor on day shift. The staffing plan is given to the Evening/Night Supervisors so that changes can be annotated during the evening and night shifts.

d) A supervisor on each shift will use the reports to document staffing changes, nursing care hours, and the census. The reports will be returned to the Section Supervisors.

e) The reports will be stored in the Nursing Human Resources Office, and eventually archived for future use.

3) Discrepancies in available versus required staff will be cross-referenced with the master staffing schedule on each unit.

5. RESPONSIBILITIES.

a. Hospital Commander:

1) Overall responsibility for ensuring safe patient care throughout the medical center.

2) Consults with the Deputy Commander for Nursing (DCN) and Deputy Commander for Clinical Services (DCCS) on patient acuity and staffing capability.

3) Determines actions to be taken when patient care requirements are projected to exceed safe staffing levels.

b. Deputy Commander for Nursing (DCN):

1) Advises the Commander and DCCS when patient acuity levels exceed safe staffing capability.

2) Collaborates with Clinical Nursing Section Chiefs and Department Chiefs on current staffing status and methods used to staff patient care areas.

3) Overall responsibility for ensuring the implementation, utilization and evaluation of nursing staffing plans.

c. Evening/Night and Holiday/Weekend Clinical Nursing Supervisors:

1) Serve as designees of the DCN to ensure adequate nursing staffing throughout the inpatient and emergency department areas at all times.

2) Evaluate and redistributes nursing staff at the beginning and throughout the shift as the census fluctuates. Assess staffing needs for subsequent shifts and activates a plan for coverage as needed.

3) Collaborate with unit charge nurses to determine patient acuity changes and staffing requirement changes.

4) Collaborate with charge nurses and fill additional staffing requirements by requesting contract agency nurses, requesting staff work overtime, and/or by notifying permanent staff of requirements and altering work schedules.

5) Collaborate with physicians to place newly admitted patients on units where staffing is adequate and/or move patients to units with adequate numbers of qualified staff to provide needed care.

6) Notify the DCCS and Chief of Critical Care Nursing of projected staffing inadequacy and request diversion of ambulances from the Emergency Department, Critical Care, or the Operating Room as applicable.

7) Notify the DCN of the staffing situation and request guidance regarding curtailment of services or diversion of patients to other care settings or emergency action.

d. Clinical Nursing Section Chief:

1) Assesses recommended requirements with availability throughout the section, and reallocate resources to meet patient care needs. If resources are not available within the section, Clinical Nursing Section Chiefs coordinates with fellow Clinical Nursing Section Chiefs to determine whether resources can be exchanged across the sections.

2) In coordination with house staff physicians, assesses patients who may be transferred to another unit or discharged.

3) Notifies the DCN or Chief, Nursing Administration if inadequate staff. When supplemental staffing options are exhausted, coordinates with physicians and the nursing leadership to determine a plan for staffing the patient care area. If adequate nurse staffing levels cannot be reached, consults with nursing and physician leadership on a recommendation to the Commander and DCCS for curtailment of services, diversion of patients or other appropriate action(s).

e. Unit/Ward Head Nurse/Charge Nurses:

1) On a daily basis, ensure that patients are classified according to WMSN and that accurate data are entered into manpower accounting systems.

2) On daily basis, monitor the nursing care hours and assess the capability of the staff to meet the patient care requirements.

3) During duty hours, Head Nurses will notify the appropriate Clinical Nursing Section Chief and Deputy Commander for Nursing when patient care needs exceed availability/capability of the staff. After duty hours, Charge Nurses will notify the appropriate Head Nurse and E/N Supervisors for reassessment and action.

4) Staffing will be adjusted by redistributing personnel, optimizing use of contract staff, and military/civilian overtime to meet the mission and/or emergency conditions.

6. EVALUATION: The following criteria will be used to evaluate the adequacy of nurse staffing plans:

a. Human Resources Indicators. The DCN and Chief, Nursing Administration will evaluate on an ongoing basis:

1) Nursing turnover/vacancy rate

2) Nursing care hours per patient day

3) Nursing skill mix

4) Use of contract staff

5) Levels of nurse staff satisfaction

b. Patient Outcomes. The nursing leadership will evaluate risk management and patient safety outcome trends on an ongoing basis to include patient falls, medication errors, and skin breakdown.

c. Data on trends in staffing indicators, including human resources and patient outcomes, will be collected monthly and reported from the Head Nurses/NCOICs to the Nursing Chiefs. The data will be given to the DCN and Chief, Nursing Administration. Data will be compared to research-based benchmarks, analyzed to determine the effects of nursing staffing on patient outcomes, and recommendations will be made to improve patient care and maximize staffing effectiveness.

//original signed//
JOAN P. EITZEN
COL, AN
Deputy Commander for Nursing